Chapter 5

Treatment of Child Crime Victims

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Introduction

This chapter reviews some of the kinds of harm suffered by children at the hands of others and considers some of the remedies for those harms. The chapter contains guidelines and principles for treatment and summarizes some evidence-based treatment studies and reports of treatments that have been considered successful.

Task Force Guiding Principles

Because there is a great range of types of victimization and great diversity in individual victim characteristics (for example, coping style, traumatic symptoms, family functioning and support systems), no specific treatment can be proscriptively matched to a specific set of symptoms.

We make six basic assumptions about child and adolescent victims. These are presented below, with their implications for treatment:

- Development is important. The effects of trauma vary with age. Developmentally immature children are at higher risk both for abuse and for more serious sequelae. The developmental status of the child together with the circumstances of the trauma should guide the selection of treatment methods.

- Context is important. Children are generally less able than adults to separate themselves from their family or living contexts. The younger the child the more this applies. The treatment plan must take into account the assets and liabilities of the child's living circumstances. Safety, stability, and the availability of "good enough" parents or caregivers (Winnicott, 1965) are prerequisites of effective treatment.

- Diagnosis is only part of the process. DSM–IV applies less well to children, because it does not take development into account. It essentially presupposes normal development with the intrusion of psychopathology. However, posttraumatic stress disorder is pleiomorphic, meaning that the same trauma can result in many and different symptoms. In children, PTSD can manifest such a variety of symptoms that the child could receive several Axis I diagnoses, based just on phenomenological findings. It is important that the behavior of the child being evaluated is described, not just diagnosed. Another clinician reviewing the records should be able to arrive at a diagnosis based entirely upon the description of the child in the records.

- Target symptoms or areas of impaired functioning should be specified and a treatment strategy developed. Treatment modalities are tools. Adequately trained therapists use these tools in specific and relevant ways. Treatment plans must specify the target symptoms, the treatment strategy, and the rationale for treatment modalities. The treatment plan should also make clear that the use of psychotropic medication has been considered and is either being pursued, deferred, or rejected.

- Treatment must be beneficial. At some point a child should converge on a better developmental trajectory, even if this does not occur quickly. The therapist should become less essential, and the child should be better able to communicate with and derive comfort from, his family or

caregivers. The treatment plan should describe the outcome being sought in terms that permit an assessment of progress.

- The treating clinician should have training specific to the treatment of child trauma victims. That training should include both academic or postgraduate training and supervised work experience.

In summary, an appropriate child treatment plan should do the following:

- Take into account a child's developmental status
- Specify treatment goals that are achievable and that address the presenting problems
- Employ methods that have empirical support or the support of extensive expert opinion in peer review publications
- Include parents or caregivers in the treatment plan in a meaningful way
- Include consultation with other adults who may have a significant role in the child's well being (for example: teachers or health care providers).

Treatment Effectiveness

Ideally, providers should select treatment methods based on substantial empirical evidence of effectiveness, such as well-controlled double-blind trials or overwhelming clinical consensus. The next most desirable treatments are those based on some empirical evidence (such as case series and open trials) or strong clinical consensus. Some treatment practices are acceptable, although there may be insufficient empirical evidence to recommend them as best practices or clinical standards. Treatment methods should be avoided when they have little or no empirical evidence or clinical support.

In recent years, studies of treatment methods which have roots in cognitive, social learning, and behavioral treatment models have clearly demonstrated the usefulness of these methods in treating child trauma victims. Therapies rooted in psychodynamic theories present greater methodological problems and have not been much represented in the recent empirical research. However, the growing availability of better technology for assessing changes in neurological functioning shows great promise for examining changes from many methods of therapy, including psychodynamic approaches.

At this point in time, we have data which indicate that a variety of methods — when practiced responsibly and competently — can produce positive outcomes for trauma victims. We lack data to make conclusive statements about which methods are best employed under which circumstances. We have data indicating that the choice of methods can make a difference in outcome. As a matter of professional responsibility, practitioners should seek to equip themselves with several therapy tools that have empirical support for effectiveness. Reliance on a single method for all patients is sure to hinder therapy with some child trauma victims.

Therapy takes place within a relationship. No matter how skillfully a particular therapeutic technique is employed, failure to establish a therapeutic relationship will reduce the effectiveness of the treatment. In some cases, the relationship may be the "active ingredient" which enables the technique to be effective.

One of the unique characteristics and challenges of conducting therapy with children is the need to establish and maintain a positive working relationship with the child's parents or caregivers. A positive alliance between therapist and caregivers is required to provide optimum treatment to children. Parents who support the therapeutic process accompany the child to the therapy sessions consistently, maintain treatment progress at home, discourage behaviors that are counterproductive to therapy, encourage feedback about the child's behaviors and symptoms, and work to make positive changes in parent-child relationships. In addition, collateral contacts with others, such as teachers and health care providers can be vital to the success of any treatment plan.

Psychotherapy Approaches

Psychotherapy comprises a broad range of treatment approaches. It is based on a process of exploration (usually verbal) and intervention to alleviate fears, worries, and troublesome behaviors. The expression of those in therapy can be a matter of direct verbal communication. They can also be a matter of indirect communication through play, artwork, and the behavior which a therapist believes to be symbolic of unspoken fears and worries. Therapies differ with respect to the emphasis they put on direct versus indirect communication, the degree to which they permit inferences about indirect communications, and the conceptual model used to explain the reasons for the kinds of interventions therapists are permitted to make.

All of the psychotherapies take place within a relationship which requires some degree of consent and trust on the part of the patient. The objective of all of the psychotherapies is to reduce the frequency of the worries, fears, and troublesome behaviors that interfere with healthy development and functioning. Empirical validation of the effectiveness of various psychotherapies in reaching that objective differs with the method. Methods which rely on direct communication, which are more explicit in their instruction of the elements which comprise the therapeutic process, and which formulate their goals in behavioral terms are more available to validation. Methods which give weight to both direct and indirect communication introduce more subjective factors and a greater range of contingencies for permissible therapist responses. Those methods often describe their goals in terms which require inferences about the implications of behaviors for postulated underlying psychic structures. Validation of the latter methods is usually more anecdotal and relies on expert opinion rather than empirical evidence. Therapist characteristics in all methods are obviously crucial, but frequently elude description.

Treating children who have been traumatized by crime should not be attempted by the beginning level psychotherapist unless supervised by an experienced clinician. The material presented will be painful to both the child and the clinician. The therapist needs to be knowledgeable and confident in his or her ability to form a relationship (therapeutic alliance) with the victim and in some cases must assist the child through the process of remembering and experiencing the events that caused the trauma. This is a process that can be difficult, but which is often necessary to the healing and recovery process. Less experienced therapists may avoid the abuse experience in a mistaken attempt to help the child feel better or because they believe that the child is too fragile to cope with painful memories. In some situations it is the therapist that is uncomfortable with the abuse-related material. The therapist's avoidance gives the child the impression that not even a grown-up who is there to help can face the enormity of the traumatic experience. This attitude can deprive the child of a safe place to acknowledge the reality of the abuse, the importance of survival, and the potential for recovery.

Trauma-Focused Treatment

Therapists who treat child trauma victims must become thoroughly familiar and comfortable with what can be called the models of trauma-focused treatment. Berliner (1997) designates treatment that is organized specifically around the trauma as Trauma-Specific Treatment. The treatment goal is successful emotional and cognitive processing of the event. Education is provided to the child and family by the therapist. If disturbing events can be described, and the responses to them understood, then out-of-proportion attributions for the event and the abuse-related coping responses can be contained, avoiding the development of more serious consequences over time.

The pace and timing of engagement of trauma-specific issues must be tailored to the needs of the individual client. Mental health treatment of children is often an episodic treatment course, not a continuous one. However, treatment that continues for months with no direct focus on trauma-related issues should be re-evaluated.

The following therapy goals for children are based on the trauma recovery model developed by Judith Herman (1992). It may not be possible to attain each of these goals during any given course of treatment:

- Management and reduction of avoidance symptoms, when present and interfering with functioning
- Communication of memories related to traumatic events, when disturbing and interfering with functioning
- Expression and management of emotions, especially those related to traumatic events
- General symptom reduction and relief
- Correction of cognitive distortions (especially related to abuse and responsibility)
- Resolution of grief and mourning, as applicable
- Behavior containment and self-regulation (especially aggressive and abuse-reactive sexual behavior)
- Strengthen positive self-identity, family and social connections
- Support child in coping with CPS/Court Involvement

One of the primary characteristics of trauma-focused therapy is that it places responsibility for finding a way to work with the trauma squarely on the therapist. Most children do not voluntarily bring that subject to therapy without help, and they do not voluntarily return to it in subsequent sessions if their first attempt results in being flooded-by distressing feelings they cannot manage. It is the job of the therapist to find a way to bring the trauma into the therapy, and to adjust the intensity such that the child can re-experience some level of the distress associated with the memories without being overwhelmed.

Treatment Modalities

It is assumed that all therapists are familiar with the various treatment modalities: individual, couple, family, and group therapies. This section examines each of those modalities from the point of view of psychotherapy for child trauma victims.

Individual Therapy

The conventional picture of individual psychotherapy as two people sitting on chairs — or one laying on a couch — and conversing is not typical for individual psychotherapy with children. The process can take place on the floor, under the chairs, or behind the couch. The task for the therapist is to discover how best to use the treatment environment to allow the child to be comfortable while exploring emotionally significant thoughts or play themes.

It is also the task of the therapist to figure out how to deal constructively with a child's tendency to use activities to avoid thoughts and feelings which have emotional significance. Set limits? Reflect? Interpret? Redirect? Ignore? One's preferences in therapy responses will be guided by one's preferences in therapy models, but the practice of trauma-focused therapy requires that the therapist be able to choose comfortably among the many possible responses at any given time

This recommendation for competence in a variety of responses does not exclude application of a specific therapy technique, or even manual-based treatment. The recommendation simply acknowledges the fact that, while trauma resolution therapy has a single goal, the diversity of children and their circumstances when they enter therapy will guarantee that no single technique will suffice for all in reaching that goal.

Individual treatment with young children usually involves an activity in addition to a verbal dialogue. Children, in general, do not have a high tolerance for sustained, face-to-face dialogue with adults and their usual experience with such conversations occurs when they are in trouble for something. They are even

more likely to feel uncomfortable discussing emotionally distressing events. Activities allow the therapist and child to interact at one level while communicating at another. Activities can be neutral in their emotional significance and chosen simply as a vehicle for interaction while trauma-related feelings and beliefs are discussed, or they can be the focus of treatment themselves. An example of the latter is reenactment of trauma-related feelings in play or artwork.

Therapists who are doing trauma-focused treatment must exercise thoughtful judgment in guiding the selection of activities or play themes that occur in a session. The goal is to choose activities or influence the choice of play themes that will facilitate the process of trauma resolution.

Play Therapy

Play therapy (Gil, 1991; Webb & Terr, 1999) is a widely used therapeutic method for individual treatment of young traumatized children (ages three to seven). As children mature and develop the capacity to benefit from cognitive-behavioral or insight-oriented interventions, play therapy is usually combined with more verbal intervention strategies. Play therapy has roots in the work of Virginia Axline (1947) and is defined by the Association for Play Therapy (1997) as the use of play, guided by a theoretical model, "to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development." The use of play therapy as a treatment method with young traumatized children rests upon expert opinion and clinical literature. Play therapy does not readily lend itself to empirical studies, although some clinicians are beginning to use standardized outcome measures to assess client progress in response to treatment interventions.

Young children have limited ability to assess their own internal emotional states and to communicate directly in words about thoughts and feelings. Play is the young child's method of interacting with the world and communicating with others. Through play, children gather information about the world, express feelings, experiment with social roles, practice new learning, and acquire understanding about relationships. Play helps children to gain mastery over internal problems such as fears and anxieties, and external challenges (such as social relationships).

Just as talking with adult victims does not always lead to trauma resolution, not all play with children is of therapeutic benefit in recovery from trauma. There are important differences between play therapy and routine play with children, differences which are often poorly understood by parents, caregivers and novice clinicians. The effectiveness of play therapy depends on the ability of the therapist to understand the child's communication through play and to respond in ways that help lessen the child's distress and improve the child's functioning. The play themes and play characters that carry the action can be understood as a metaphor for concerns that the child cannot otherwise articulate, or indeed which may not be part of the child's conscious awareness. Play by itself may be fun, but for it to be considered therapy, there must be articulable reasons for what the activities are, and how they are intended to reduce symptoms or problems.

Following traumatic events, many young children express disturbing memories and emotions through posttraumatic play, a spontaneous and repetitive form of play that re-enacts (directly or symbolically) aspects of the trauma (Terr, 1981, 1991). While some traumatized children are able to release feelings about the trauma and gain mastery from play that is entirely self-directed, many develop anxious and repetitive patterns of unresolved posttraumatic play. Therapeutic assistance is often needed to guide the play so that the child's communication becomes clear and exposure to distressing memories and emotions can be managed at a pace and intensity the child can handle. The gradual remembering and communicating about the traumatic event through play constitutes a process of desensitization and mastery of the experience. A skilled and creative clinician can use play therapy to help a child transform posttraumatic reexperiencing into an emotionally corrective experience, guiding the child toward resolution and integration of the trauma.

There are both directive and nondirective approaches to play therapy, although an integrated model is most commonly used in abuse-focused treatment. Typically the therapist provides the child with an assortment of toys, including some that might evoke themes related to the traumatic event. Such toys include dolls and

puppets (to represent people), dollhouses, dress-up clothes, doctor kits, police cars, rescue vehicles, telephones, and so on. The therapist observes the child's spontaneous patterns of play and notes the themes that recur or seem relevant to the crime and its aftermath.

The therapist must decide whether, or at what point, to introduce verbal interpretation or discussion of the themes expressed by the child's play. For some therapists, this decision rests upon a particular theoretical model of the play therapy process. For others, it is a more individualized choice, depending on the stage of therapy and the child's capacity to tolerate and benefit from verbal processing. How and when to integrate verbal processing with metaphor or symbolic play is a central aspect of play therapy which depends on the art of therapy (clinician creativity and intuition), rather than on science (treatment models and research). There are times when words have little to add, such as when a child's play scenario demonstrates powerful restorative themes.

Despite such moments, most play therapists use both non-verbal and verbal expression, helping children develop a cognitive framework for overwhelming experience. Through play scenarios, the therapist helps the child to identify and express emotions, confusion or distortions about the traumatic event, and ideas about what the child wishes could have been different. The child's capacity to imagine alternative scenarios or outcomes, often in response to the therapist introducing themes of assistance, rescue or safety, can be an important step in helping the child regain a sense of safety, justice and competence. The therapist supports play that adds insight and meaning to the child's experience and facilitates resolution of the traumatic event.

Expressive Therapies (Art and Sand Tray)

Nonverbal treatment methods such as art therapy and sand tray therapy provide children (and adults) with a way to communicate about distressing events in a symbolic, indirect, and distanced manner. These methods allow the client to better control how much traumatic memory they can allow themselves to acknowledge and reexperience. The use of art therapy and sand tray with traumatized children is based primarily upon expert opinion and clinical literature.

Art therapy is a method of nonverbal communication that enables traumatized children to express their own perceptions and feelings. In the words of one therapist, "Art is a medium of expression beyond words. It is deeply felt in the soul." (Davenport, 1999). Although many children talk with therapists about their artistic creations, the therapeutic benefit of drawing, painting, collage, or sculpting occur primarily in the creative act itself. Art helps children to make order out of chaos and helps bring a sense of control back into their lives (Gil, 1991). Art helps children to express and manage difficult emotions such as anger, fear or anxiety. In *Breaking the Silence: Art Therapy with Children from Violent Homes* (1997), Malchiodi explains, "For children who have been abused or have witnessed violence in their homes and are often silent in their suffering, art expression can be a way for what is secret or confusing to become tangible."

Although a small number of therapists have formal graduate-level art therapy training, most develop their art therapy skills through continuing education workshops, books, and clinical supervision. As with sand tray, art therapy for trauma resolution is usually combined with other verbal and nonverbal treatment methods. Clara Jo Stember was an early pioneer in the use of art therapy with sexually abused children and their families (Natoive, 1982). Levinson (1986) used an Art and Play Therapy approach (APT) with burned children in a hospital setting, identifying themes of hurt, sadism and ambivalence toward abusive family members in their art work. Terr (1990) made an important connection between play and art therapy by her observation that the artwork of traumatized children is similar to posttraumatic play, including repetitive themes and the failure (at times) of artwork to relieve a child's anxiety without therapeutic assistance.

Sand tray therapy is a technique in which a client arranges sand and miniatures (figures and objects) in a tray of either dry or wet sand, to create a static or moving world (De Demenico, 1993). Developed by Margaret Lowenfeld (1950) and called Sand Tray World Play, the method was adopted and integrated with Jungian theory by Dora Kalff (1971). Although there are some clinicians who use Sand Tray as their only therapeutic method, most clinicians who treat traumatized children consider it to be one of a number of expressive

techniques for encouraging nonverbal or symbolic communication. Traditional sand tray work typically follows strict rules that limit verbal interaction between therapist and client during creation of the sand tray scene. Discussions about the meaning of the scene are deferred until the scene is completed and the meaning of the scene is drawn from the client's experience, rather than therapist interpretations. Sand tray work with traumatized children tends to be more flexible in approach, using both directive and non-directive approaches. Children are more likely than adults to narrate a story about the scene they are creating or to invite the therapist to play interactively with them. In trauma-focused sand tray work, the clinician ensures that the child has miniatures available that allow the creation of sand tray scenes relevant to their own specific traumatic event.

Parent and Family Therapy

A child's recovery from trauma depends significantly on the capacity of parents and caregivers to provide emotional support (Cohen & Mannarino, 1996, 1998; Browne & Finkelhor, 1986). Therapy with traumatized children should routinely include collateral sessions (individual, family or group therapy) with parents or caregivers, who need to understand the impact of trauma on their children as well as how to assist their child's recovery by helping children manage anxiety and other crime-related problems. They play an important role in reinforcing children's coping skills and helping children to develop accurate cognitive attributions about why the crime occurred and who is responsible. Parent or caregiver treatment participation is even more essential when children display externalizing problems (such as aggression, enuresis or sexualized behaviors), which require the adult's cooperation in implementing and monitoring parts of the treatment plan.

Parents or caregivers who are experiencing significant levels of distress may require their own treatment. Some parents develop psychological problems in response to their child's victimization, including depression, anxiety and posttraumatic stress symptoms. Other parents have their own unresolved maltreatment histories and have reexperiencing symptoms triggered by their child's victimization. These emotional disturbances in parents can interfere with their ability to support their child's recovery. Group and individual treatment for parents who have been abused themselves can be valuable in resolving childhood issues and improving overall parental functioning. Some trauma intervention programs use treatment teams within an agency — or closely collaborating therapists from different agencies — to coordinate treatment interventions for children, parents or caregivers, and siblings traumatized by crime. Treatment goals for parents or caregivers typically include the following:

- Decreasing trauma-related symptoms.
- Improving the ability to emotionally support and nurture the child.
- Increasing the ability to protect their child from further harm.
- Encouraging non-abusive parenting techniques.
- Developing healthy boundaries with their child.
- Correcting cognitive distortions or inappropriate attributions regarding responsibility for the crime.
- Providing support with court or system contacts.
- In some cases, intervening with substance abuse, psychiatric problems, or the parent's own history of unresolved trauma.

Assessment of the extended family system is strongly advised to determine potential support and resources to lessen parental stress. History-taking which considers familial patterns of coping with stress, discipline practices and the existence of intergenerational child abuse can provide valuable information. This history-taking should be sensitive to cultural factors. Cultural beliefs may support the use of physical discipline that may be considered excessive when compared with the prevailing community practices. Understanding of

cultural issues can increase the chances that the discipline practices within a family can be altered without the family perceiving that it must abandon its cultural heritage. The therapist should obtain consultation on cultural issues when treating a family with a cultural background unfamiliar to the therapist. For more information, see the chapter on "Multicultural Issues."

For further information regarding effective treatment when child maltreatment occurs within the family system, see the chapter on "Treatment of Intrafamilial Crime Victims."

Group Therapy

Group therapy is a widely used treatment modality, especially with older children and adolescents. It has often been considered the treatment of choice for sexually abused children and teens, although no research data exists showing group therapy to be superior to other treatment modalities. The popularity of group treatment rests in part on its ability to serve greater numbers of children, as well as clinical experience that some children and adolescents are more comfortable talking about traumatic events with groups of their peers than they are in the more intense, one-on-one focus of individual treatment.

The task force considers group therapy to be beneficial in many cases, either as a primary or adjunctive therapeutic modality. However, it is not an appropriate or necessary intervention in all cases. Group therapy can be of greatest benefit to those victims who feel isolated, alone or stigmatized, or who display impaired social skills due to early neglect or deprivation. Group therapy provides a comparison with the feelings and responses that other children have after being abused or neglected, which helps the young victim recognize that their own feelings are not abnormal (Mandell & Damon et al., 1989). Group therapy can provide a corrective experience for children who have learned aggressive or non-empathetic ways of treating others. It can reduce isolation by helping children develop a sense of belonging and improved social skills. With the therapist's help, the child may identify with and learn from peers and group leaders. However, group therapy may not be appropriate for a child who cannot communicate well in words or who would be disruptive in group due to disturbed or impulsive behavior. Such children may not be accepted by the group and would experience rejection, rather than therapeutic benefit. A child with limited social skills may need individual therapy prior to the interpersonal demands of group therapy. Finally, group therapy participation is not recommended when children are involved in criminal court proceedings, since questions may arise about the degree to which a child's testimony could be influenced by experiences shared by other group participants.

Three Recommended Treatment Models

In the next section, three specific therapy models are described. These models were selected to illustrate differences in the range of available models. The SOCTF has confidence in the efficacy of these models when practiced correctly, but they should not be regarded as exclusive recommendations. Others will be reviewed in the revisions and updates of this volume. The three models reviewed below include a method which follows a specific treatment protocol to attain its goals (Cognitive Behavioral Therapy); a model in which the methods and goals are described but are less proscriptive and which gives the therapist more latitude of response and, accordingly, more responsibility (Integrated Contextual Model); and a method where the focus is entirely on child-caregiver interaction and where the therapist functions as a coach for the caregiver (Parent Child Interaction Therapy).

Additional "exposure" models will be reviewed in the adult crime victim volume, including Eye Movement Desensitization and Reprogramming (EMDR) and hypnotherapy. EMDR's efficacy with children has been less well-documented. While self-hypnosis has been used effectively with children for pain control, wider applications in that age group are more problematic. The adult volume will also include a model of behavioral treatment for sexually reactive adolescents and a discussion of some special treatment topics, such as treatment of Dissociative Identity Disorder.

Cognitive Behavioral Therapy

Cognitive therapies generally challenge detrimental thoughts and beliefs in logical, evidence-based manner. Cognitive Behavioral Therapy (CBT) (Berliner, 1997; Cohen & Mannarino, 1998, 1993) proceeds by direct exploration and discussion of the traumatic event, applying exposure methods, desensitization and relaxation techniques. With the therapist's support, the patient works to explore inaccurate causal attributions regarding the trauma, to recognize and interrupt self-blame and survivor guilt, and to learn to cognitively reframe the event. This strategy is augmented by behavioral rehearsal, and contingency reinforcement for behavior problems. When the patient is a child, inclusion of parents in the treatment process makes the treatment much more effective. CBT is based on an assumption that there is a powerful relationship between thoughts, feelings and behaviors, and that this relationship is malleable, and can be influenced by working on the cognitive component (Deblinger & Heflin, 1996). Empirical evidence from controlled treatment outcome studies provides the strongest support for use of trauma-focused CBT to resolve PTSD symptoms. Treatment components are direct discussion of the trauma, increase in emotional and cognitive coping skills, correction of cognitive distortions, and contingency reinforcement for children with behavioral problems. Stress management techniques, for example through systematic relaxation, image induced relaxation and controlled breathing are taught. Cognitive coping techniques are also taught, including thought replacement, such as mentally picturing a stop sign, or interrupting disturbing thoughts and focusing on positive experience or memories and making positive coping self-statements such as "I am strong." The traumatic experience is directly explored with exposure techniques, for example, developing a fear hierarchy, practicing direct exposure as when the therapist asks the patient to "describe the room you were in and everything you visualize," or embarking on in vivo exposure, as when the patient returns to situations that evoke the traumatic memory. The therapist works with the patient to correct inaccurate attributions, to teach the child about the "cognitive coping triangle" (the relationship between thoughts, feelings and behaviors), and to dispute negative thoughts. For example, together they may play out that a puppet or a friend is having the fears or frightening thoughts, and the child is encouraged to convince them that these thoughts are not true.

Reports of this treatment emphasize the techniques of treatment rather than the relationship between the therapist and patient. Accordingly descriptions of treatment alliance factors focus on compliance with treatment. Adjunctive and consultative services are not described as part of the treatment; however, as noted below, when parents are constructively included in the treatment, it is more effective. The child is also helped to generate positive self-statements. In one study of treatment (Cohen & Mannarino, 1998) sexually molested preschool children were found to benefit from a 12-session course of CBT more than from supportive therapy. This depended as well on parental and family factors; if the mothers were also given support and, if in turn, they could give the child support, children functioned better at 6-month follow-up, whereas, if the parents had continuing distress, the child's outcome was not as good.

The Integrated Contextual Model

An integrated model of treatment for child trauma victims has been proposed by Friedrich (APSAC Handbook, 1996). The Integrated Contextual Model assumes that to understand the impact of abuse on children, and to intervene to mitigate its effects, it is necessary to focus not only on the effects specific to the trauma, but also on the historical and familial contexts in which the trauma occurs. Those contexts, Friedrich asserts, can amplify the effects of the specific trauma(s) and must be addressed in the treatment plan if a child is going to recover adequately. For example, a child who is abused in the context of a disorganized family in which the primary attachments are not secure and in which the primary caregivers themselves have a personal history as victims of abuse will have a problematic course in treatment if only the trauma-specific effects are identified as the focus of treatment.

The therapist-child relationship is the foundation of treatment in the Integrated Contextual Model. That relationship — if developed properly — offers a corrective attachment experience, which in turn is expected to cause a modification of the internal construct for attachment which governs anticipations and the child's own attachment behavior. The therapist must also provide the structure and the tools necessary for the child to reexperience traumatic events in a manner which is tolerable and eventually allows for mastery of the

threatening and disorganizing feelings related to the trauma. The therapist also plays a central role both in helping the child to modify self-perceptions, and helping the family members (non-offending) to remodel negative or rejecting perceptions of the child into more positive perceptions.

The validity of the Integrated Contextual Model is a construct validity which rests on the data underlying the theoretical models on which it is based. The research and practice accomplishments of its author lend additional credibility ("expert consensus"). The model derives from the following sources:

- Attachment theory, particularly the work of Alexander (1992)
- The role of affect regulation in behavior and social relationships (Dodge & Garber, 1991)
- The role of self-perceptions in emotional development (Harter, 1988; Meichenbaum, 1974).

Friedrich identifies specific treatment goals that follow from these underlying models and some suggested methods for achieving those goals in individual, group, and family therapy.

Although the Integrated Contextual Model is clearly based on psychodynamic considerations, Friedrich cautions against relying on "insight" or "self-examination" as goals in therapy with children, since these capacities come late in development. Instead, Friedrich emphasizes the experiential aspects of the therapy and the means for creating and guiding experiences.

The Integrated Contextual Model borrows extensively from CBT for tools for treating affect dysregulation connected to specific traumas and for treating distorted or negative self-perceptions. It goes beyond CBT in attempting to repair and modify internal constructs that influence attachment behavior, and it takes a more active and far-reaching role in intervening in family relationships. Because of the scope of the intervention in the integrated model, going beyond PTSD or trauma-related symptoms, it is less proscriptive in the specificity of its methods than CBT. The effectiveness of the Integrated Contextual Model relies more on the therapeutic relationship and the clinical resources of the therapist than it does on specific methods of treatment. Because this model is more ambitious in its scope and multi-factorial in the variables it is treating at a given time, it is less amenable to conventional methods of empirical validation. An additional problem is that the model's emphasis on therapist personal competence factors makes control of treatment fidelity (that is, is it the method or the therapist that accounts for outcomes?) an almost impossible methodological problem. At the same time, it should be noted that Friedrich makes assessment of treatment outcome, using standardized and objective methods, an ethical responsibility of the therapist. Such assessment can be done whether or not one can assess the contribution of therapist versus method to the outcome, or whether one can identify the "active" elements in the method and therapist which contribute to the outcome.

Parent-Child Interaction Therapy (PCIT)

When it is determined that improved parent-child interaction is a treatment goal, structured parent-child treatment may be appropriate. A therapist observes parents through a one-way mirror as they interact with their children, and providing the parent with direction on how to respond to the child physically and verbally. Other parent-child interaction methods are based on group experiences in which the parent and child participate with others in activities designed to increase positive parent-child interactions and improve parenting skills. PCIT is a behavioral and interpersonal dyadic intervention for young children (ages 2–8 years) and their parents or caregivers. The goals are to decrease externalized child behaviors, such as defiance and aggression, and to increase positive parent behaviors, and improve the quality of the parent-child relationship. Many factors contribute to the development of physically abusive family patterns. Abusive parents have high rates of negative interaction, low rates of positive interaction, and have rigid or ineffective strategies for teaching and disciplining their children. Children who have been physically abused are frequently oppositional, defiant and aggressive. Negative coercive parent-child relationship patterns may escalate to the point where the parent inflicts severe corporal punishment and physical abuse (Urquiza & McNeil, 1996). When this pattern of interaction becomes an entrenched way of resolving parent-child conflicts, risk for child maltreatment escalates. While there are many different types of physically abusive

parent-child relationships, this cycle may explain a preponderance of this pattern of violence by parents against their children.

PCIT targets specific deficits often found within physically abusive parent-child dyads. It has been shown to be effective with both high-risk families (for example, families with oppositional, defiant children) and physically abusive families by incorporating both the parent and the child (and other involved family members). The implementation of PCIT involves a parent and child interacting and playing with age-appropriate toys while being observed through a one-way mirror. The parent wears a FM-signal audio reception device ("bug-in-the-ear") to listen to prompting and instructions from the PCIT therapist observing in the adjacent room. The PCIT therapist observes specific interpersonal dynamics and behaviors and then guides the parent with prompts or direction. With such coaching, parents improve aspects of their response and see that their child's compliance rapidly improves, and the child quickly decreases his negative and inappropriate behavior. The positive parent changes are immediately reinforced, and the quality of the parent-child relationship is quickly ameliorated.

Assessment of Treatment Progress

For all treatment methods, ongoing assessment of progress is essential. The task force recommends that this be done through specific inquiry with the child and parent as well as through standardized assessment (as described in the chapters on "Assessment" and "Evaluating Treatment Outcome"). The therapist should regularly:

- Assess treatment effectiveness.
- Amend or modify treatment services.
- Acquire feedback from client.
- Amend or modify treatment objectives.
- Assess the need to seek consultation.
- Assess the need to continue or terminate treatment.

If substantial symptom reduction does not occur after six months of treatment, and the lack of progress cannot be attributed to a significant external event (such as failure of family support, court involvement, change in foster placement), the provider is strongly encouraged to review and revise their treatment plan, seek consultation, or consider possible referral to a different provider.

Psychotherapy Summary

In summary, the Task Force agreed on the following concepts:

- Psychotherapy for most children does not begin as a voluntary act. They are told that they need to go and are delivered at an appointed time. An experienced child therapist can usually overcome that inauspicious beginning and form a working relationship with the child. To transform that positive relationship into a therapeutic relationship is the real task. It is a task that is more easily accomplished if the child is given some role in the formation of the therapy goals and is given reason to feel personal achievement in progress made toward meeting those goals.

- If any gains made in the therapy hour are to survive and generalize, the child must be living in a safe environment which offers some opportunities for affection and encouragement. An hour or two each week in the therapists office can accomplish many things, but it cannot overcome the effects of an unsafe or uncaring living environment.

- A treatment plan which does not include the child's caregivers in some important measure will take longer to show progress, be less substantial, and in the case of young children have little chance of any success.

- Children usually avoid talking about things which make them feel anxious or sad. Waiting for a child trauma victim to focus on the trauma which caused their referral for treatment will be a futile wait. It is the responsibility of the therapist to find a way to make the trauma and its sequelae a part of the therapy in a form the child can tolerate.

- All therapy occurs within the context of a relationship. Therein lies a potential problem, because therapy relationships are just as susceptible to influences that are outside conscious awareness as any other relationships, and not all of those influences are consistent with the goals of the therapy. Therapists who rely more on manual-based treatment methods may be less apt to intrude on their patient's therapy in unintended ways, but no one is exempt. It is important for therapists to undergo their own therapy of self-exploration and to find ways of continuing to do that throughout the course of their career as therapists, if they are going to minimize the frequency of and extent to which they project their own biases into their patients' therapy.

- Know the limitations of your ability to practice your craft and in your development as a psychotherapist. Some disorders are more difficult to treat then others, some symptoms more intractable or dangerous. Posttraumatic stress disorder is one of these. Know when you need more preparation and when you need consultation before proceeding. Good intentions are not enough.

- Know the limits of psychotherapy. It is not the purpose of psychotherapy to instruct people about whom they should love or befriend, about what choices they should make in their lives, or what values they should cherish. There is nothing in our training that gives us that wisdom and nothing in the psychotherapy relationship that gives us that authority. The obvious truth is stated here because therapists who treat child trauma victims often feel a compelling urge to do all of those things in an effort to protect them from future harm. Psychotherapy cannot change what has already happened and cannot make everyone whole. Psychotherapy at its best can limit the harm the past can do in the present, and it can give hope for the future.

Pharmacotherapy

The use of psychotropic medication in the treatment of child trauma victims is an area in need of additional research. Currently, the use of medications with children is guided primarily by what is known about the risks and benefits of medication use with adult trauma victims. Areas of concern also include knowledge about medications and client access to services. Most of the mental health providers who treat child trauma victims in California are not physicians. The child psychiatrists who practice in this field — in California and nationally — are notable but few in number. Non-physician mental health providers might not always appreciate the value of psychotropic medication as an adjunctive treatment in their therapy, and those who do may not have access to a consultation with a child psychiatrist. The result too often is that psychotropic medication is not considered when it should be; or medications are prescribed by physicians other than psychiatrists, too often without adequate psychiatric or mental health consultation.

The following section is written by a child psychiatrist who is also the medical director for the California Department of Mental Health. Its intended audience is both physicians and non-physicians. Some of the terms and information contained in this section may be unfamiliar to non-physician readers. Where that is the case, it is recommended that the reader make every effort to become familiar with the terms and information because ethical and informed treatment of child trauma victims requires that the possible benefits of psychotropic medication be considered as an important component of treatment planning. When child clients are receiving psychotropic medication, therapists should obtain authorization (see the "Legal Issues" chapter) and consult with the child's physician regarding the treatment plan. Clinicians may have information about the child that the physician needs in order to make medical decisions about the child's care. The non-physician reader who requires more background information on the actions of psychotropic medications as well as their risks and benefits are encouraged to read the short introductory book by Preston and Johnson (2000), Preston et al. (1998), and Williams (1999).

The information below is provided as a beginning point for dialogue on the subject. The task force requests feedback from the larger professional community regarding their clinical experience regarding the use of medications with traumatized children. Of particular interest are topics such as underutilization, overutilization, client access to psychiatric services, and clinician access to psychiatric consultation.

Pharmacotherapy with Children

When a person takes a psychoactive drug, what changes? Does the drug directly produce a change in his mental state coinciding with the activity or level of the drug? Alternatively, if the person's brain reacts to the drug with a change in state, is it secondary to activity of the drug to up-regulate or down-regulate a particular configuration of synapses? Or does the drug alter the probabilities of structuring or restructuring the person's neuronal connections? Finally, how do the answers to these questions differ if the person is a child?

Animal data demonstrates that developing neurotransmitter systems are exquisitely sensitive to early inhibition or stimulation by pharmacological agents (Riddle et al., 1993). These influences lead to permanent changes in the animal's brain that persist into adulthood. We know from clinical observation that human infants exposed to drugs prenatally possibly have teratogenic or growth-altering effects in their brains. Recent imaging studies provide evidence for functional or morphological restructuring in the adult brain following treatment with medications (Mogilner et al., 1993). Newer quantitative imaging techniques, such as functional neuroimaging in normal volunteers, outlines the contributions of the noradrenergic, cholinergic and dopaminergic neurotransmitter systems to the neurochemical modulation of human attention and arousal (Coull, 1998).

In a child's brain there is active development of neurological excitation and response. It is difficult to imagine that we could construct a pharmacological treatment to stabilize the child's reactions in such a complicated adaptive system. To illustrate this, we can consider the treatment of inattention in children with "uncomplicated" ADHD. Psychostimulants are recognized as effective in a majority of such patients (Musten et al., 1997). But new knowledge about the neurobiology of attention (Castellanos et al., 1996; Chabot & Serfontain, 1996; Ernst et al., 1994; Filipek et al., 1997) shows it to be a complex phenomenon. Noradrenergic and cholinergic systems are involved in low-level aspects of attention (for example, attentional orienting), while the dopaminergic system is associated with more executive aspects (for example, attentional set-shifting or working memory). Multiple neurotransmitters are involved in moderating attention, and the neuronal systems involved are distributed throughout the brain, from brainstem through basal ganglia to cortex, with input from the limbic system, hippocampus and amygdala. Thus no medication, no matter how specific its effect on a particular neurotransmitter, can have a specific effect on attention. Pharmacological action involves primary, secondary and *n*-level effects in a dynamic system.

Effects of psychoactive medications on brain development are mostly unknown. However, it is know that trauma and stress can have lasting effects on brain development and can reset equilibration points for homeostatic processes such as heart rate and response threshold (Post & Weiss, 1997). Psychiatric disorders may be developmental or chronic or both. Treatment may need to be protracted. However, pharmacological treatment can affect the developing brain. We lack pre-clinical models to describe brain development and lack clinical models for assessment methods to monitor subtle developmental effects of drugs.

Psychotropic medication can be overused or underused. Naive therapists who underdiagnose neurobiological disorders may enjoy a false confidence in their ability to talk a suffering patient out of a biological condition. On the other hand, naive therapists who apply simplistic causal algorithms to complex behavior constellations may recognize all excessive activity or impulsivity as Psychostimulant Deficiency, all sadness as an Antidepressant Deficiency, all moodiness as a Mood Stabilizer Deficiency and so on. They might then pitch their diagnosis to a physician who may guilelessly (or hastily) prescribe medication to suppress "symptoms" which are the wholesome protest of a stressed child. They may even find published articles to substantiate their treatment plan. It has also been shown (Jensen, 2000) that suffering children whose symptoms interfere with developmentally appropriate activities, and who have symptoms that would respond to treatment with medication, often do not receive it.

Since victimization often occurs in situations where many other things are going wrong in the family or in the parent child relationship, the child's developmental patterns, in adapting to that situation, may already be abnormal. A child with a combination of blighted attachment or a chaotic environment or PTSD (with attendant biological alterations in neuroregulation) may have almost any symptoms. Such children have received any and all diagnoses in DSM-IV, and many of them receive more than one Axis I diagnosis. Children whose non-psychiatrist physician providers are persuaded by their naive therapists to prescribe psychotropic medication are put at unnecessary risk. Conversely, children with untreated pathology are also at risk. For example, untreated ADHD is associated with later school failure and conduct disorder; untreated depression is associated with later substance abuse.

Because early trauma can produce protean symptoms, children often receive multiple DSM-IV Axis I diagnoses. This situation invites co-pharmacy (the use of two or more medications, such as an anxiolytic and a psychostimulant) or polypharmacy (the use of two or more similar medications, such as two antidepressants or two antipsychotics). It may be necessary for the physician to try agents individually before combining them, avoiding compounding agents from the same class (such as two serotonin reuptake inhibitors), and changing an ineffective medication rather than treating the side effects of one medication with a second medication.

In contrast to reports of non-pharmacological treatments, reports of treatments with medication are typically evidence-based. However, the evidence upon which the reports are based, is often ambiguous. There are few reports of randomized controlled trials for children with posttraumatic stress disorder. As described, psychiatric comorbidity confounds interpretation of results. Moreover, since no medication acts specifically on one brain area or function, there is always a mixed response to all drugs. Few studies systematically compare the relative efficacy of medications with non-pharmacologic therapy or in combination with other therapies.

Selective serotonergic reuptake inhibitors (SSRIs) have been found to be superior to placebo in veterans (van der Kolk, Dreyfuss, et al., 1994) and civilians (Davidson et al., 1997). Currently SSRIs are regarded as first-line medications for children with anxiety and mood symptoms. Monoamine oxidase inhibitors (MAOIs) have been found effective in veterans (Kosten et al., 1991) in comparison with tricyclic antidepressants, particularly for intrusive symptoms. MAOIs are possibly better than SSRIs for intrusive symptoms, but newer medications such as nefazadone (Serzone) and venlafaxine (Effexor) may be better than MAOIs.

Tricyclics, however, also produce some improvement, primarily for re-experiencing symptoms, but not for arousal and avoidance symptom clusters. Benzodiazepines are not regarded as effective and are not recommended as a primary treatment of core symptoms of PTSD (Braun et al., 1990). Other applied medications are suppressors of noradrenergic activity (anticonvulsants), which may be effective in reducing avoidance, numbing and arousal symptoms.

Because no symptom stands alone, no treatment can be devised that is completely specific to a particular symptom. Yet psychotropic medication is often proposed as a specific treatment. For example, anxiolytics, antipsychotic medication, or mood stabilizers may be recommended for anxiety, disordered thought, or over-reactivity. The physician may be called upon to prescribe a medication that turns off a symptom or turns the gain up or down on its intensity. It is unrealistic to conceive a plan for pharmacological intrusion upon a developing neurotransmitter system that has such simple effects.

Working with partial information, how should the physician treat a child with posttraumatic stress disorder? Pharmacological treatment should be rational, context-relevant, and integrated with the rest of the child's treatment. Rational use of medication means that a target symptom — consistent with the diagnosis — is identified for any drug prescribed. The physician and therapist should identify, together with the child and parent, what the symptom is and how it will be tracked or measured. This engages the patient and his caregiver in an alliance with the physician to observe what is happening and allows everyone to agree about whether the medication is working or not.

Context-relevant use of medication means that after the treatment response has been determined, the physician assesses outcomes across all pertinent domains, follows the child's reaction to the medication, and maintains an open mind to the contribution of the child's adaptive responses to his symptoms.

Pharmacological treatment should be integrated with the rest of the child's treatment. This presumes comprehension and communication among the child, the family, treating physicians, and therapists. Medications may be requested if the child's symptoms emerge, increase, or persist. The physician must evaluate whether the symptom change is a correlate of helpful treatment (for example, strengthened self-assertion or improved verbal abilities), or fallout from treatment that might do harm (for example, flooding the child with stimulation like that which cause the trauma, inserting false memories, or forcing disclosure). The child's symptoms cannot be expected to abate if the home is unsafe and the perpetrator still threatens. To medically blunt symptoms that result from dangerous situations or harmful interventions is to add injury to insult.

Various pitfalls can be encountered during treatment of a child. The most common one is failure to evaluate the accuracy of parent reports. Baseline laboratory measures as well as follow-up measures should not be neglected. A second pitfall is mistaking treatment of the symptom for treatment of the patient. Symptom reduction can occur even when overall functioning remains seriously impaired. In any case, medications should not be discontinued abruptly.

Clarifying the treatment frame and therapeutic policy with the family is important in the treatment of every child. However, with pharmacological interventions, the stakes may be higher and the communication more critical for families tossed in the wake of violence, arrests, losses, and protective services involvement, or for those that care for foster children. Confidentiality, triggers for child abuse reporting; parameters for medical follow-up, for laboratory monitoring, and for compliance; financial and reimbursement issues; and tactics for exchanging information with schools and other agencies, must all be decided and agreed to. Realistic and unrealistic expectations of medication treatment may be confusingly intertwined, so it must be remembered that consistently clear communication fosters realization of therapeutic goals. Effective pharmacological intervention with children is far more complex than simply obtaining a prescription.

Although the scope of this psychopharmacology discussion may be more detailed than the non-physician mental health treatment provider is accustomed to, the task force encourages clinicians to consult with psychiatrists more frequently and to consider a combination of psychotherapy and medication as of benefit to some child trauma victims.

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